praised it in the following terms: "It is unquestionably the handsomest compendium of operative surgery that has yet appeared, and, withal, so compactly as well as clearly arranged, that we are inclined to think that it may prove even more useful than it is ornamental. . . . . With the best wishes for the success of a publication which does the highest honour to good taste, enterprise and judgment of all concerned, we most cordially recommend it as on all accounts worthy of a prominent place in every medical library, or on every office table." This book was furnished to army surgeons by the United States Government during the Civil War.

OTHER AMERICAN PHYSICIANS WHO STUDIED UNDER BERNARD

During the years 1845-1865, when Bernard was most active, there were nearly one hundred American physicians whose short biographies in Kelly and Burrage's American Medical Biographies show that they continued their medical studies by a year or so in France. In only a very few instances, however, is it specifically stated that the individual actually worked under Bernard, but we can add to the list of those already mentioned the names of Alfred L. Kennedy (1818-1896), who was with Bernard in 1848, immediately after obtaining his M. D. from the University of Pennsylvania, and William H. Mussey (1818-1882), who graduated from the Medical College of Ohio in 1848, and was with Bernard in 1851. The American students in Paris formed a society which they called the American Medical Society of Paris, and Mussey was elected its president during the year that he was there.

BROWN-SÉQUARD'S RELATION TO BERNARD

No list of those who brought Bernard's teaching to America, however abbreviated, should omit the name of that roving genius, Brown-Séquard (1817-1894), who moved back and forth between France and the United States like a shuttle in a loom. Posthumous son of an American father by a French mother, he had completed his medical studies in Paris under the greatest handicaps in 1846, and, like Bernard, had attempted to do experimental work in out-of-the-way holes and corners. He is reported to have lived in a garret with no stove to alleviate the dank chill of the Parisian winter, while hutches of rabbits and guinea-pigs contaminated the atmosphere. Bernard refers to Brown-Séquard as one of those physiologists who had to leave France because of lack of support in his chosen profession. In 1852 he thought he might fare better in his father's native land, and took passage in a sailing boat for the United States. He purposely chose so slow a vessel in order that the length of the voyage might permit him to learn English. Under the patronage of distinguished physicians in Boston, New York, and Philadelphia, he lectured on the discoveries of Magendie and Bernard, and even performed some original experiments. He returned to France, but in 1855 accepted for a short time a professorship at the Virginia College of Medicine in Richmond. Again he crossed the Atlantic, only to return once more to hold for a brief three years (1864-1867) the professorship of the physiology and pathology of the nervous system at Harvard. Unfortunately, Brown-Séquard did not remain long enough in this country to be instrumental in doing for physiology here what Bernard was doing for that science in France, though he was considered worthy to succeed Bernard as professor of medicine at the Collège de France in 1878.

(To be continued)

CLINICAL NOTES AND CASE REPORTS

SUCTION APPARATUS FOR BLADDER OR DUODENAL DRAINAGE

By H. H. PARSONS, M. D.
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MANY different kinds of apparatus are in use throughout the country for the creation of mild continuous suction such as is used in suprapubic bladder or duodenal drainage. They consist, for the most part, of bottles, old syringes and rubber tubing, and very often are makeshift affairs, not understood by the nurses, so that the surgeons frequently need to refer to diagrams in order to construct them.

In order to overcome these disadvantages, I constructed and have used, for the past four years, the apparatus described below. It is inexpensive, efficient, requires little storage space, and is always ready for use.

It is made from the following parts, and connections may be provided by soldering or threading the various parts, as shown in the diagram:

A —Hollow brass wire, $\frac{3}{16}$ inch outside diameter, 2 inches long.
B —Copper tubing ¼ inch outside diameter, 36 inches long.
C —Hollow brass wire $\frac{3}{16}$ inch outside diameter, 32 inches long.
C'—Copper tubing ¼ inch outside diameter, 10 inches long.
D —Brass tubing ¼ inch outside diameter, 6½ inches long.
E —Copper tubing ¼ inch outside diameter, 1½ inches long.
F —Brass "T."
G-G'—Brass plugs, threaded and shaped as shown in diagram.

The parts are assembled and made air-tight by soldering, and the tubes *B* and *C* may be soldered together for rigidity.

For use, the apparatus is lashed to the upright of an irrigator stand, so that the lateral, *E*, is on a level with or below the point to be drained. Rubber tubing connects *E* to the drainage point. The intake, *A*, is connected to an irrigator can by means of rubber tubing, and the flow is controlled by a Hoffman cutoff. A Murphy drip glass may be inserted in the line if desired. Rubber tubes are connected to the distal ends of *B* and *C*, and their free ends immersed in water in separate vessels on the floor.

By filling the irrigator can and partially emptying the two floor receptacles occasionally, continuous suction is maintained.

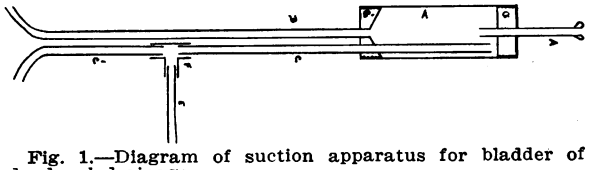

Fig. 1.—Diagram of suction apparatus for bladder of duodenal drainage.

A —Hollow brass wire $\frac{3}{8}$ inch outside diameter, 2 inches long.
B —Copper tubing ¼ inch outside diameter, 36 inches long.
C —Hollow brass wire $\frac{3}{8}$ inch outside diameter, 32 inches long.
C'—Copper tubing ¼ inch outside diameter, 10 inches long.
D —Brass tubing ¾ inch outside diameter, 6½ inches long.
E —Copper tubing ¼ inch outside diameter, 1½ inches long.
F —Brass "T."
G-G'—Brass plugs, threaded and shaped as shown in diagram.

The water dropping from *A* through *D* leaves by way of *B*, thus creating a partial vacuum in *D* and *C*, but the lower end of *C'* being submerged the suction is made manifest in *E*, which is connected to the site to be drained. Fluid entering *E* runs down the lower part of *C'* and does not go up into *D*.

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EPIDIDYMITIS—SOME CLINICAL OBSERVATIONS

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THERE are several valuable points of clinical interest to the general surgeon and clinician relative to acute and chronic inflammatory reactions within the epididymis. It would be only a reiteration of known knowledge to classify the several types and enumerate the usual textbook symptomatology; and my purpose, therefore, in this short paper is to draw attention to a few outstanding features relative to epididymal inflammations, trusting that they may be of some value in the office or at the bedside.

Clinical practice seems to reveal the fact that support, properly applied, is more important in promoting resolution of inflammatory conditions of the epididymis (non-tubercular) than any type of local application one may use. Smearing the scrotum with black, glycerinated concoctions promises little, except a black and messy dressing.

The following adhesive plaster dressing may be tried: Use an ordinary gauze flat, roll it (tightly) lengthwise like a cigar and run a strip of plaster, one-half inch wide, around and down the length of it, similar to the "barber pole" stripe. This will keep the gauze from unrolling. Tear off a strip of plaster, one inch wide and about eight inches long, and lay the gauze-roll lengthwise and in the center of the adhesive side of the strap. Lay the scrotum flat upon the abdomen and strap the gauze-roll in place, transversely across the perineum and behind the testicles, running the ends of the adhesive plaster up to either groin and thus forming a sling, behind which the testicles will not slip, as the gauze-roll acts as a barrier. Next, strap the scrotum and contents against the abdomen with two-inch adhesive, applied transversely. Do not worry about the dressing impeding the act of urination, as the patient will manage satisfactorily. Add new supports to this dressing as needed. Immediate cessation of pain and the ability to get around actively is the result that may be expected from this treatment.

Examine the cord frequently in cases of acute epididymitis. A "pipe stem" sensation imparted to the examining fingers points to funiculitis of the cord. It is best not to play tag with this condition. Open up the scrotum, free the fascia about the cord well up to the external ring, slit the epididymal sheath, drain freely with penrose through the lower end of the scrotum and sew up the original incision with black silk. Temporize with this condition and abscess of the testicle with resultant orchidectomy will be your penalty.

Persistence of marked epididymal swelling after ten days, pain and soreness failing to subside early, temperature persisting after five days—any or all of these signs in evidence means epididymal, and possibly testicular abscess, and diagnoses a surgical scrotum. Do not drain an acute eipdidymitis that reveals pus. Do an epididymectomy.

Always explain to the patient, preoperatively, that the testicle may be abscessed and a removal of the same may be necessary, so that your endeavor to do conservative surgery upon an epididymis, showing pus, will leave you a loophole through which you may sneak back later and do an orchidectomy, because ten chances to one that is precisely what you will have to do. Drainage of the acute epididymis by early multiple punctures may be all right, but if you find any pus in those needle holes, then remove the epididymis at once.

In dealing with epididymitis in the elderly individual, do a bilateral vasectomy. I believe that severing the vas, especially on the affected side, will break the continuity for absorption from the vesicle and prostatic area.

There are two points to bear in mind in doing scrotal surgery for tuberculosis. First, considering the frequency of tuberculosis in other parts of the body, in patients with scrotal tuberculosis you must prepare yourself to combat a rapid flare-up of some other tubercular rest following your scrotal surgery. As a popular cartoonist puts it: "They'll do it every time." Perhaps not every time, but sufficiently frequent to keep one busy enough. You may think that ligation of the vas, high up, and cauterization will prevent this distressing aftermath; but sad experience has taught me the fallacy of this theory. Such procedure is important and necessary, but do not be surprised if things happen to cause much concern later on.

The second point to which I wish, in conclusion, to call attention to is closure in scrotal surgery for tubercular conditions. Leave the scrotum wide open and pack with iodoform gauze. Expect a sinus, or perhaps two or maybe three; then, if your patient surprises you and heals without a sinus, you will be happily disappointed.

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